



REFERRAL FOR MORRISON OUTPATIENT SERVICES

PLEASE FAX COMPLETED FORM TO (with RELEASE OF INFORMATION)

CENTRAL INTAKE AT (503) 872-0659
or call Intake Call Center Phone # (503) 258-4381

Client: _____ DOB: _____

___ Oregon Health Plan # _____
___ Uninsured (if so, pls include the info below)
Hshld income _____ #of in hshld _____
*MCFS requires clients be eligible for OHP

Date of Referral: _____

Legal Guardian: _____ Relationship to client _____ Phone # _____

Person child lives with: _____ Relationship to client _____ Phone # _____

Client's address: _____

Client's school: _____

Parent/caregiver is aware of this referral and agrees to being contacted by Morrison? _____ No

Will family need a Spanish-speaking therapist? ___ Yes ___ No

Will family need other language interpreter services? ___ Yes ___ No If Yes, which language? _____

Referring Provider Name & Phone #: _____ EXT _____

Agency/Program: _____

Release of Information Obtained? ___ Yes (Please fax with this form) ___ No (though patient agreed to be called)

Service(s) Requested:

- Outpatient Mental Health Alcohol and Drug Assessment (AOD)

Identified Concerns/Observations: _____

Client's Primary Care Physician: _____ Phone No. _____

Significant illness/health information: _____

Medications: _____

Morrison Site requested:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Portland
1507 NE 122 nd Ave.
Portland, OR 97232
(503) 258-4555 | <input type="checkbox"/> Gresham
912 NE Kelly Ave, #200
Gresham, OR 97030
(503) 258-4600 | <input type="checkbox"/> Beaverton
14025 SW Farmington Rd. #160
Beaverton OR 97005
(503) 258-4495 | <input type="checkbox"/> Oregon City
1713 Penn Lane, Ste B
Oregon City, OR 97045
(503) 258-4545 |
|--|--|---|---|

**MORRISON CALL CENTER STAFF WILL CONTACT PARENT/GUARDIAN
TO SCREEN AND SCHEDULE INTAKE APPOINTMENT**

This form is available on-line for download at www.morrisonkids.org – click on “Get Help”